Ben Novell, MS, LMFT, LPCC
Marriage and Family Therapist
State License MFC25733

Janelle K. Novell, MA, LMFT, RPT-S
Marriage and Family Therapist
State License MFC32101

Client Information Form

Client Name	Address
First: Last:	Street: City: State: Zip:

Check box for preferred call number

☐ Home Phone	☐ Cell Phone	☐ Work Phone	Email Address
( )	( )	( )	

DOB	SSN	Driver's License #

Marital/Relationship Status	How long in current relationship?

Occupation	Employer/ School
Employer/ School Address	
Street: City: State: Zip:	
How long at current employer?	

Insurance
Insurance Address
Street: City: State: Zip:

List all family members living in your home	Age

Client Information Form (cont'd.)

Reason you are seeking counseling?

If you were referred here, who referred you?

Have you ever been seen by a Psychiatrist, Psychologist or Counselor?		
Yes (☐) No (☐) If Yes:		
Who?	**When?**	**Where?**
For What Reason?		

In Case of Emergency Contact	Address		
First: Last:	Street: City:	State:	Zip:
Relationship	**Home Phone**	**Cell Phone**	**Work Phone**
	( )	( )	( )

Responsible Party

(If Client is a Minor or has Conservator)

Name	Address		
First: Last:	Street: City:	State:	Zip:
Check box for preferred call number			
☐ Home Phone	☐ Cell Phone	☐ Work Phone	Email Address
( )	( )	( )	

DOB	SSN	Drivers License #

Occupation	Employer

Employers Address
Street: City: State: Zip:

Signature	Date

Client Information Form (cont'd.)

Additional Responsible Party

Name	Address
First: Last:	Street: City: State: Zip:

Check box for preferred call number

☐ Home Phone	☐ Cell Phone	☐ Work Phone	Email Address
( )	( )	( )	

DOB	SSN	Drivers License #

Occupation	Employer

Employers Address
Street: City: State: Zip:

Signature	Date

Ben Novell, MS, LMFT, LPCC
Marriage and Family Therapist
State License MFC25733

Janelle K. Novell, MA, LMFT, RPT-S
Marriage and Family Therapist
State License MFC32101

Consent for Group Participation

Client's Name: _____

DOB: _____

Name of Group: Grief Therapy

This is to certify that I have given permission for my child to participate in small group treatment. The group environment will provide your child with an opportunity to openly share and discuss thought and feelings with other children in a safe and supportive environment.

California state law mandates the reporting of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse.

All actual or suspected acts of child abuse will need to be reported to the appropriate agency.

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian